



Dublin City School District
Emergency Medical Authorization Form

Students
5341 F1
Revised 4/5/10

Complete Both Sides

Student Name: _____
(Last Name) (First Name) (Middle Initial)

Home Address: _____
(Street) (City/State/Zip) (County)

School Attending: _____ Teacher/Team: _____ Grade: _____

Parent(s)/Guardian with whom student resides: _____

Mother: _____ Home Phone: _____ Father: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Work Phone: _____ Cell Phone: _____

*Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

*This information will be shared with staff and emergency care providers if needed.

In the event you cannot be reached, list two local people to whom you authorize the school to release your ill or injured child.

Name: _____ Name: _____

Home Phone: _____ Cell Phone: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Work Phone: _____

Relationship to Student: _____ Relationship to Student: _____

Please list facts concerning the child's medical history, including allergies, medications being taken, and physical impairments to which a physician should be alerted.

Allergies: _____
(List what your child is allergic to) (Type of reaction) (Usual treatment)

Medical Condition: _____

Medications/Treatment: _____ Physical Impairments: _____

According to ORC 3313.712, a legal parent/guardian must sign either the Consent for Treatment or the Refusal to Consent for Treatment. Please sign EITHER Option I OR Option II (do not sign both):

OPTION I: CONSENT FOR TREATMENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical

Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature: _____

Address: _____ Date: _____

OPTION II: REFUSAL TO CONSENT FOR TREATMENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Parent/Guardian Signature: _____

Address: _____ Date: _____